Group Medicare Advantage Enrollment Request Form

CareFirst Medicare Advantage

Who can use this form?

People with Medicare who want to join a Group Medicare Advantage Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Group Medicare Advantage Plan, you must be determined eligible to enroll by your group administrator and also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

Please refer to your enrollment materials for information on when you can enroll in this Group Medicare Advantage Plan.

Note: If you and your spouse or Medicare-eligible dependent are applying, each of you will need to fill out a separate enrollment request form.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

What happens next?

Send your completed and signed form to:

Calvert County Public Schools - HR Department

1305 Dares Beach Road

Prince Frederick, MD 20678

You may also send the completed form via email to:

benefits@calvertnet.k12.md.us

Questions?

For eligibility and enrollment questions, call:

Calvert County Public Schools - HR Department

443-550-8315 or 443-550-8330, M-F 8:00am-4:00pm

For benefit plan questions, call:

CareFirst BlueCross BlueShield Medicare Advantage

833-939-4103 (TTY: 711)

Monday through Friday 8:00 am to 6:00 pm ET

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

SECTION 1—ALL FIELDS IN THIS SECTION ARE REQUIRED (UNLESS MARKED OPTIONAL)

Select the plan you want to join:

◯ **CareFirst BlueCross BlueShield Group Medicare Advantage (PPO)**

CONTACT INFORMATION

Employer or Union Group Name
Calvert County Public Schools

First Name	Last Name	Middle Initial (optional)

Birth Date	Sex ◯ Male ◯ Female	Home Phone Number	Mobile Phone (optional)

Permanent Residence Street Address (Don't enter a PO Box. Note: For individuals experiencing homelessness, A PO Box may be considered your permanent residence address.)

City	County (optional)

State	Zip Code

Mailing Address, if different from your Permanent Address (PO Box allowed):

City	State	Zip Code

Email Address (optional)

MEDICARE INFORMATION

Medicare Number	Part A Effective Date	Part B Effective Date

ANSWER THESE IMPORTANT QUESTIONS

Will you have other prescription drug coverage (like VA, TRICARE) in addition to CareFirst BlueCross BlueShield Medicare Advantage? ◯ Yes ◯ No

Name of other coverage	Member number for this coverage

Group number for this coverage

SECTION 2—ALL FIELDS IN THIS SECTION ARE OPTIONAL

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select if you want us to send you information in a language other than English.

◯ Spanish

Select one if you want us to send you information in an accessible format.

◯ Braille ◯ Large print ◯ Audio CD ◯ Data CD

Please contact CareFirst BlueCross BlueShield Group Medicare Advantage at the number listed in your enrollment materials if you need information in an accessible format other than what's listed above.

Our office hours are Monday through Friday 8 a.m.–6 p.m. ET. TTY users can call 711.

SECTION 3—IMPORTANT: READ AND SIGN BELOW

- I must keep both Hospital (Part A) and Medical (Part B) to stay in CareFirst BlueCross BlueShield Group Medicare Advantage.
- I understand that I can be enrolled in only one Medicare Advantage plan at a time—and that enrollment in this plan will automatically end my enrollment in another Medicare Advantage plan (exceptions apply for MA PFFS, MA MSA).
- By joining this Group Medicare Advantage Plan, I acknowledge that CareFirst BlueCross BlueShield Group Medicare Advantage will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that when my CareFirst BlueCross BlueShield Group Medicare Advantage coverage begins, I must get all of my medical and prescription drug benefits from CareFirst BlueCross BlueShield Group Medicare Advantage. Benefits and services provided by CareFirst BlueCross BlueShield Group Medicare Advantage and contained in my CareFirst BlueCross BlueShield Group Medicare Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor CareFirst BlueCross BlueShield Group Medicare Advantage will pay for benefits or services that are not covered.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:

  1) This person is authorized under State law to complete this enrollment, and

  2) Documentation of this authority is available upon request by Medicare.

Signature	Today's Date
If you're the authorized representative, sign above and fill out these fields	
Name	Address
Phone Number	Relationship to Enrollee

EMPLOYER GROUP USE ONLY	
Employer or Union Group Name Calvert County Public Schools	
Subgroup Name/Number (if applicable)	Employer Group Number
Employer Receipt Date	Authorized Representative Name

SECTION 4—TO BE COMPLETED ONLY BY INDIVIDUALS ASSISTING THE ENROLLEE WITH THIS FORM	
Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members or other third parties) helping an enrollee fill out this form.	
Name	Relationship to Enrollee
Signature	National Producer Number (Agents/Brokers only)

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-833-939-4103 (TTY: 711) or speak to your provider.

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-833-939-4103 (TTY: 711) o hable con su proveedor.

French

ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-833-939-4103 (TTY : 711) ou parlez à votre fournisseur.

Simplified Chinese

注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-833-939-4103（文本电话：711）或咨询您的服务提供商。

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Korean

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-833-939-4103 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

Yoruba

ÀKÍYÈSÍ: Tí ó bá jẹ́ pé o ń sọ èdè Yorùbá, àwọn iṣẹ́ ìtọ́jú ìrànlọ́wọ́ èdè wà ní àrọ́wọ́tó fún ọ. Àwọn ohun èlò ìrànlọ́wọ́ àti iṣẹ́ ìtọ́jú tí ó yẹ láti pèsè àlàyé ní àwọn àwòṣe tí ó ṣe é lò wà ní àrọ́wọ́tó lọ́fẹ̀ẹ́ bákan náà. Pe 1-833-939-4103 (TTY: 711) tàbí kí o bá olùpèsè rẹ sọ̀rọ̀.

Amharic

ማሳሰቢያ፡- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-833-939-4103 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።

Tagalog

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-833-939-4103 (TTY: 711) o makipag-usap sa iyong provider.

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-833-939-4103 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

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Arabic

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-833-939-4103 (711) أو تحدث إلى مقدم الخدمة.

Russian

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-833-939-4103 (TTY: 711) или обратитесь к своему поставщику услуг.

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-833-939-4103 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Farsi

توجه: اگر [وارد کردن زبان] صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 1-833-939-4103 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.

Vietnamese

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-833-939-4103 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

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Portuguese

ATENÇÃO: Se você fala [inserir idioma], serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-833-939-4103 (TTY: 711) ou fale com seu provedor.

Urdu

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔-1 833-939-4103 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

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